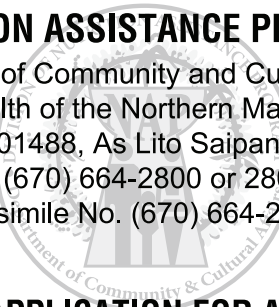


# NUTRITION ASSISTANCE PROGRAM

Department of Community and Cultural Affairs  
 Commonwealth of the Northern Mariana Islands  
 P.O. Box 501488, As Lito Saipan MP 96950  
 Tel. No. (670) 664-2800 or 2802-2818  
 Facsimile No. (670) 664-2850



OFFICIAL USE ONLY	
RETAIL & REDEMPTION UNIT	
F.S. No.: _____	Date Received _____

## APPLICATION FOR AUTHORIZATION TO PARTICIPATE IN THE NAP

1. NAME OF CORPORATION _____ DBA _____ LOCATION _____	2. NAME OF OWNER <i>(include address and telephone number if different from items 1 and 3, or name and address of district manager if a chain store).</i>
3. MAILING ADDRESS OF RETAIL FIRM _____	4. NAME OF PERSON RESPONSIBLE FOR OVERALL OPERATION <i>(If different from item 2).</i>
5. TELEPHONE NUMBER OF RETAIL FIRM _____	

6. DO YOU NOW OWN OR OPERATE, OR HAVE YOU PREVIOUSLY OWNED OR OPERATED A FIRM FOR WHICH AN APPLICATION TO PARTICIPATE IN THE NUTRITION ASSISTANCE PROGRAM WAS SUBMITTED? *(If "YES," give the name of the firm and when the application was submitted.) (If "NO," give the date the firm indicated in Section 1 above opened for business.)*

NO \_\_\_\_\_  YES \_\_\_\_\_

7. CURRENT RETAIL GROSS VOLUME OF SALES \$ _____	8A. CURRENT FOOD SALES <i>(Dollar Amount)</i>	8B. CURRENT FOOD SALES <i>(Percent of Gross Sales)</i> _____ %
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9. LOCAL FOODS ARE:  IF LESS THAN 25%, *(Please indicate actual percentage)* \_\_\_\_\_ %

25% OR MORE  50% OR MORE  75% OR MORE OF FOOD SALES

10A. TYPE OF FIRM (CHECK ONLY ONE)	or	10B. COMBINATION STORE (CHECK ONLY ONE)
<input type="checkbox"/> SUPERMARKET (SM) <input type="checkbox"/> MEDIUM DIZED OR SMALL GROCERY STORE (GS) <input type="checkbox"/> CONVENIENCE STORE (CS) <input type="checkbox"/> SPECIALTY FOOD (MEAT, FISH, ETC.) (SF) <input type="checkbox"/> WATER & ICE COMPANY <input type="checkbox"/> OTHER (Specify) _____		<input type="checkbox"/> GROCERY/GAS STATION <input type="checkbox"/> FISH/PRODUCE MOBILE <input type="checkbox"/> ROADSIDE VENDOR/MARKET (FISH/PRODUCE) <input type="checkbox"/> BAKERY <input type="checkbox"/> OTHER COMBINATION (Specify) _____

11. DOES THE FIRM SELL ALCOHOLIC BEVERAGES? <input type="checkbox"/> YES <input type="checkbox"/> NO	12. WHERE WILL YOU REDEEM YOUR FOOD STAMPS? <i>(Give name and address Bank)</i>
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13. CERTIFICATION My signature at the bottom of this form means the following:  I am applying for Authorization to take part in the Food Stamp Program.  I have read and understand the regulations that govern the Program.  My firm (including all employees) will comply with the Program Regulations.	I understand that the NAP, DCCA, can revoke my Authorization to Participate for any violations by any of the firm's employees, owner or officers. I will update the information on this Application each year, and submit any other information requested by the NAP, DCCA. All information in this Application are true. I understand that any false information may mean that the NAP, DCCA, will deny or withdraw approval to participate. I have the authority to contact NAP regarding the firm.
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Print Name, Title & Signature of Applicant Firm	Date
Reviewed by RRU Staff (Signature/Initial)	Date

**IMPORTANT NOTE:** This Application will not be processed or approved unless all items are completed and all required documents are submitted. New or renewed of authorization will not be approved unless a completed Application has been received, and provided that all program requirements are satisfied accordingly. NAP, DCCA, shall deny or approve authorization, or require more information, within thirty (30) calendar days of receipt of application.

NAP Form/RRU-408 (Revised 06/20)